Summary of NUBC Meeting
11/13/2000 – 11/14/2000
By
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NUBC Role in Designated Standards Maintenance Organization (DSMO)

It was clear that by being named by the Secretary of Health and Human Services as one of the original DSMO participants, the NUBC would assume new roles. There will be a need to balance a commitment to share with the other DSMO organizations without losing autonomy for functions that rightfully should be decided by the NUBC. It was agreed that organizations that currently route changes through the NUBC should be encouraged to continue. Changes where there is any doubt that the NUBC should not be the sole keeper of that request should routinely be shared with other DSMO organizations.

It was announced that the first closing period for DSMO changes is the end of November.

The current DSMO participants (X12, HL7, NCPDP, ADA, NUCC, & NUBC) provided the initial funding for the web site (www.hipaa-dsmo.org). WEDI has been asked to fund the ongoing maintenance for this site.

Public Health Notes: It is clear the HIPAA law has already been a catalyst for greater cooperation between the DSMO participants. The lesson for public health organizations is clear. Stay involved, continue to participate in the dialog, and continue to broaden the business cases for public health data needs.

Review of 837 Implementation Guide versus the UB-92 Data Specifications

Issue # 1 – Line level Physician data

The NUBC agreed that collecting line level physician data was unnecessarily burdensome. They will initiate a request through the DSMO process to remove this requirement.

Issue # 2– Claim level physician specialty information (PRV Segment)

The NUBC agreed that collecting claim level physician specialty information was unnecessary. They will initiate a request through the DSMO process to remove this requirement.

Issue # 3 – Claim Level Referring Physician Information

The UB-92 Specifications currently do not distinguish between the referring and other physicians as in the 837. It was decided that the UB-92

Specifications manual needs to provide additional clarification on how and when to uniformly report referring physician information on the UB-92.

Issue # 4 – Attachment Report Type Code (PWK Segment) & Attachment Control Number

This segment and number do not map to the UB-92 Specifications. The issue of attachments has been debated at NUBC meetings in the past. It will be necessary to conduct further discussions with the X12 claims work group to better understand the business case for this segment before recommending further action by the NUBC.

Issue # 5 – Demonstration Project Identifier

This identifier does not map to the UB-92 Specifications. It will be necessary to conduct further discussions with the X12 claims work group to better understand the business case for this segment before recommending further action by the NUBC.

Issue # 6 – Service Date (Range Date Qualifier)

The NUBC agreed that collecting a service date range rather than a single service date would cause significant complications for provider information systems. They will initiate a request through the DSMO process to remove this requirement.

Issue # 7 – Medicare Assignment Code

The definition in the 837 differs from an assignment code definition in the UB-92 Specifications. More research is necessary before recommending further action by the NUBC.

Issue # 8 – Patient Weight

This segment does not map to the UB-92 Specifications. The issue of patient weight (collected for newborns) has been a debated at NUBC meetings in the past. It will be necessary to conduct further discussions with the X12 claims work group to better understand the business case for this segment before recommending further action by the NUBC.

Public Health Note: This is an issue that will require careful monitoring by public health systems that use this data element. It will be necessary to help justify the business case for this data element.

Issue # 9 – Delay Reason Codes

This X12 code lists closely aligns with current UB-92 condition codes. The NUBC agreed to do maintenance on the current condition codes to align with the X12 list, and then initiate a request through the DSMO process to refer to Delay Reason Codes as an external list maintained by the NUBC.

Issue # 10 – Prescription Number

This segment does not map to the UB-92 Specifications. It will be necessary to conduct further discussions with the X12 claims work group to better understand the business case for this segment before recommending further action by the NUBC.

Issue # 11– Patient Discharge Facility Type

This segment does not map to the UB-92 Specifications, but it is defined in the flat file for use by Home Health Agencies. It will be necessary to conduct further discussions with the X12 claims work group to better understand the business case for this segment before recommending further action by the NUBC.

Issue # 12 – Release of Information Code

This X12 code lists closely aligns with current UB-92 data element. The NUBC agreed to do maintenance on the current data element (Form Locator 52) to align with the X12 list, and then initiate a request through the DSMO process to refer to Release of Information Codes as an external list maintained by the NUBC. Because of possible privacy implications, this action will commence after the final privacy rule is published.

Issue # 13 – Individual Relationship Code

This X12 code lists closely aligns with current UB-92 data element (Form Locator 59). Since several other industry groups use this X12 code list, it is unlikely that control of this code list would be relinquished to any single industry group, such as the NUBC. The synchronization of the UB-92 list with the X12 list is still an unresolved issue. Further debate on this will be incorporated in with UB-02 discussions.

Issue # 14 – Special Program Indicator Codes

This X12 code lists aligns with current UB-92 condition codes. The NUBC will initiate a request through the DSMO process to refer to the Special Program Indicator Codes as an external list maintained by the NUBC.

Issue # 15 – Total Claim Charge Amount

The 837 Implementation guide uses a segment (CLM) to report this information; the flat file designates two data elements to report this information; the UB-92 Specifications assigns a revenue code to report this information. The NUBC will initiate a request through the DSMO process to use the UB-92 revenue code to report this information.

Issue # 16 – Related Causes Code

This X12 code lists closely aligns with current UB-92 Occurrence Codes. The NUBC agreed to do maintenance on the current Occurrence Code list to align with the X12 list. Because this data element is part of a composite (C024) and there are situational data elements (state or province codes) in that composite segment that do not map to the UB-92 Specifications, further NUBC action is undetermined.

Miscellaneous Issues

The field attributes between the X12 standards and the UB-92 Specifications are inconsistent. This issue is currently being addressed by HCFA.

There is an alignment issue in the 837 Professional Implementation Guide. The NUBC agreed to add further clarification in the Type of Bill frequency to resolve this alignment issue.

Public Health Notes: Though not all of these issues would impact public health data collection systems, it is important to be part of the discussions for those instances that are important to public health data systems.

State Issues

As a follow up from previous meetings, a draft of frequently asked questions for Patient Status codes. Upon approval by the committee this will be another vehicle to provide necessary clarification of UB-92 data elements.

North Carolina requested clarification on the intent of condition codes 20 (Beneficiary Requested Billing) and 21 (Billing for Denial Notice). The result of this discussion was several possible wording changes that need to be reviewed by member organizations before a vote at a future NUBC meeting.

Public Health Notes: The importance of a precise definition of data requirements used in a uniform way was highlighted by this discussion.

Coding Requests

CLIA Number Request – A place to report the number to Medicare identifying certified labs on SNF part B claims was requested. The consensus amongst

NUBC members was that the use of certified labs should be verified on post audit. There were too many collection issues to justify collection of this information on the claim. Further action on this request was tabled pending further review by HCFA.

Occurrence Span Code Request: The request code would be used to report hospital outpatient services that occur during a period of outpatient repetitive service. The principal objection to this request was that the change for the Medicare program would conflict with other payer requirements. A suggested way to avoid this conflict was that data should be reported at the lowest level of granularity. Each payer system would then be able to aggregate to the desired level using the same claim standard. Further action on this request was tabled pending further review by HCFA.

Public Health Note: The NUBC position to only support the lowest level of granularity in the standard should be supported by the public health community.

Type of Admission for Outpatient Request: Based on objections voiced during a conference call, this request has been modified. The burden to change provider systems to enable this change did not justify the benefit. The purpose of this request was to separate emergency services from consolidated bills. It was suggested that a condition code (code 59 set aside) satisfy the HCFA need. There are still outstanding questions on potential legal conflicts with the EMTALA law. Further action on this request was tabled pending further review by HCFA.

National Drug Code Request: HCFA proposed using the Description Field (Form Locator 43) to report this 11-character code. The NUBC is already on record objecting to the use of the NDC code on an institutional claim. They intend to propose a change to the law through the DSMO process. There was no further action taken on this request.

Clinical Trials Code Request: After discussion during NUBC conference calls and subsequent usage clarifications by HCFA, a condition code (30) was approved to flag bills to be paid by the clinical trial funds. The definition is as follows: "Non-research services provided to patients enrolled in a qualified clinical trial." The effective date is for dates of service on or after 4/1/2001 for outpatient claims and discharges on or after 4/1/2001 for inpatient claims.

In a follow up from previous meetings, HCFA will use 00000 in the zip code field to indicate a foreign location.

Day Program Request: The Alliance for Managed Care has requested adding a revenue category to reimburse for a day program, which is defined as a program that provides 2 or more therapy services in addition to other complimentary services. This request was tabled until more input from State committees could be solicited. There was additional discussion about other possible requests for

additional revenue codes in the near future that would require using all four digits. Included in this discussion were revenue codes for Alternative Medicine. This will also be discussed at future meetings.

UB-02

The deadline for responses to the UB-02 survey is January 2001. In addition to comments on the survey any locally defined condition, value, occurrence, and revenue codes should be identified. A possible role of the NUBC would be to act as a clearinghouse for these local codes to assist in reducing any redundancies.

Tentative Meeting Dates: in 2001

February 12 and 13 in Baltimore

May 23 and 24 in Chicago

August 6 and 7 in Baltimore

November 7 and 8 in Chicago